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Notice of Independent Medical Review Decision
Reviewer's Report

DATE OF REVIEW: August 30, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
EMG/NCV right lower extremity 99203-95860-95900-95904.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D., Board Certified in Neurology.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)
☒ **Overturned** **(Disagree)**
☐ Partially Overturned (Agree in part/Disagree in part)

The requested services, EMG/NCV right lower extremity 99203-95860-95900-95904, are medically necessary for the evaluation of this patient.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
1. Request for a Review by an Independent Review Organization dated 7/12/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 8/16/12.
3. Notice of Assignment of Independent Review Organization dated 8/16/12.
4. Request for authorization forms dated 6/11/12, 6/27/12 and 7/12/12.
5. Medical records from MD dated 5/10/12 through 6/28/12.
6. Medical records from MD dated 5/24/12 through 7/05/12.
7. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on xx/xx/xx. Per the submitted documentation, the patient was standing on a loading dock and inverted his foot. MRI of the right lower extremity reportedly showed tearing of the ligamentous tissue. On 5/24/12, the patient reported that physical therapy and work conditioning had not helped. He reported an inability to extend his ankle and pain in the right knee due to overcompensation. On 6/28/12, the medical records noted a peroneal nerve injury. Per the submitted documentation, the patient lost sensation to the dorsal aspect of the foot and had no dorsiflexion. The patient's provider has recommended EMG/NCV of the right lower extremity.

The URA indicated that the patient does not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA's initial denial indicated that due to the lack of documented evidence of neurologic dysfunction, the lack of full documentation of conservative treatment and the lack of documented efficacy or support provided for the need of nerve conduction velocity tests, the requested services are not clinically warranted. On appeal, the URA noted that there is a lack of evidence of lumbar radiculopathy to support the need for the requested services.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The submitted documentation demonstrates the medical necessity of the requested services in this patient's case. Official Disability Guidelines (ODG) note that common peroneal nerve dysfunction is damage to the peroneal nerve leading to loss of movement or sensation in the leg and foot, including foot drop. The guidelines note that electrodiagnostic studies are indicated to rule out radiculopathy, lumbar plexopathy, or peripheral neuropathy. This patient injured his foot, and the records noted lost sensation to the dorsal aspect of the foot and no dorsiflexion. In this patient's case, his condition is indicative of a peripheral neuropathy. In this clinical setting, the requested EMG/NCV right lower extremity 99203-95860-95900-95904 is medically indicated for the evaluation of this patient.

Therefore**,** I have determined the requested EMG/NCV right lower extremity 99203-95860-95900-95904 is medically necessary for evaluation of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**